INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884

August 2, 1990

INSPECTOR GENERAL INSTRUCTION 1438.3

Subject: Federal Employees' Compensation Program

References:

a. Federal Employees' Compensation Act (FECA).

b. Federal Personnel Manual 810.

c. DoD Directive 1438.3, "Injury Compensation Program," September 13, 1985.

A. Purpose

1. This Instruction provides general policy guidance and instructions and states responsibilities for establishing and administering the administrative compensation program of the Office of the Inspector General, Department of Defense (OIG, DoD). It serves as the guide for information and guidance concerning injury compensation benefits and procedures for civilian employees and managers.

2. Reference a provides the authority by which all Federal civilian employees are compensated for personal injury (or employment related disease) sustained while in the performance of duty. The Act provides ability compensation, medical care, vocational rehabilitation, and health benefits and is administered by the Office of Workers' Compensation (OWCP), U.S. Department of Labor (DOL), which adjudicates all claims. While the DOL administers the FECA program, the costs are charged to the OIG, DoD.

B. Applicability. This Instruction applies to the Offices of the Inspector General; the Deputy Inspector General; the Assistant Inspectors General; Director, Administration and Information Management; Director Departmental Inquiries; Director Intelligence Review. For purposes of this Instruction, these organizations are hereafter referred to collectively as OIG components.

C. Exclusions. The FECA does not cover an employee whose injury or death is caused by willful misconduct or by the employee's intention to cause the injury or death of self or of another person. If intoxication (of the injured employee) is the cause of the injury or death, neither the employee nor beneficiary is entitled to benefits.

D. Definitions

1. Continuation of Pay (COP) is the continuation of an employee's regular pay with no charge to annual or sick leave. It is only authorized in traumatic injury cases and only for those days that an employee is medically certified as disabled for work (up to a maximum of 45 calendar days).

2. Controversion of COP is a supervisor's right to challenge the granting of COP for an injury on a basis of one or more of the categories specified on the reverse of the Federal Employee's Notice of

Traumatic Injury and Claim for Continuation of Pay/Compensation (CA-1), Block 35, "Does the employing agency controvert continuation of pay?" (See Figure A-2). Payment of COP may also be challenged based on other reasons including fraudulent reporting or false statements by an employee and/or witness(es).

3. Light/Limited Duty is a temporary assignment of duties that enable a partially disabled employee to remain productive at the work site.

4. Occupational Disease is that which is produced by systemic infection; continued or repeated stress; exposure to toxins, poisons, noise, etc., in the work environment over a period of time (at least 2 days).

5. Recurrence of an injury is when a previously reported injury causes additional loss of time from work.

6. Traumatic injury is a wound or other condition caused by external force, including physical stress or strain which is incurred while the employee is in the performance of official duties. The injury must be identifiable as to the time and place of occurrence and the member or function of the body affected. Further, it must be caused by a specific event or incident within a single day or workshift.

7. Minor injury is an injury that is not life threatening, requires no lost time and no medical treatment other than at a civilian employee health branch or branch clinic or dispensary.

E. Policy. It is the policy of OIG, DoD, to:

1. Provide an employee injured in the performance of duty with all benefits available without delay.

2. Implement a program designed to reduce costs associated with the administration of FECA.

F. Responsibilities

1. **OIG Component Heads** shall:

a. Take personal interest in the numbers and costs of compensation claims originating at the work site.

b. Ensure that all supervisors have adequate knowledge of the FECA claims and administration process.

c. Ensure that improprieties or potential fraud and abuse are reported to the Employee Relations Division, Personnel and Security Directorate.

d. Reduce COP costs by ensuring employees return to work as soon as they are able.

e. Make every effort to ensure that light/limited duty assignments are available for returning partially disabled employees to duty.

2. An **injured employee** shall:

a. Immediately report a traumatic injury or occupational disease to their supervisor. Appendix A provides guidance for reporting.

b. If necessary, obtain authorization from the Chief, Employee Relations Division, or designee for treatment by a local (within 25 miles of the work site or the employee's home) physician/hospital of the employee's choice.

c. Complete and submit to the Employee Relations Division, Personnel and Security Directorate, Room 125, via his/her supervisor, all necessary forms and other documentation used or provided in connection with an injury/disease in a timely manner. Figure A-1 provides instructions for completing the CA-1 Form.

d. Keep the supervisor advised if the injury/disease does not permit immediate return to duty and submit on a biweekly basis Duty Status Report (CA-17) from the treating physician. The CA-17 should be submitted to the Employee Relations Division.

3. **Supervisors** shall:

a. Ensure that appropriate medical treatment is furnished for employees sustaining a traumatic injury or occupational disease.

b. In traumatic injury cases, advise the employee of the right to elect COP or use annual or sick leave while disabled for work.

c. Complete and submit to the Employee Relations Division, Personnel and Security Directorate, all necessary forms and documentation used or provided in connection with an injury or disease in a timely manner.

d. Controvert or deny an improper claim for COP on the basis of information submitted by the employee or secured upon investigation.

e. Where appropriate, provide light/limited duty assignments when a competent medical authority documents that a partially disabled employee is capable of performing light/limited duty.

f. Document available light/limited duty by completing and forwarding Certification of Light/Limited Duty Form (Appendix B) to the Employee Relations Division.

4. The **Employee Relations Division, Personnel and Security Directorate,** shall:

a. Administer the FECA program and ensure compliance with all applicable laws and regulations.

b. Provide guidance and assistance to employees who file for benefits and to supervisors in meeting their responsibilities under FECA.

c. Facilitate the processing of necessary documentation and completed compensation forms to the employee, supervisor, attending physician, and to OWCP.

G. Procedures. See Appendix A for detailed instructions.

H. Penalties for Falsification or Noncompliance

1. Any person who knowingly makes a false statement, misrepresentation of fact, or any other act of fraud to obtain compensation or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may be punished by a fine or imprisonment, or both.

2. Any official superior who fails, neglects or refuses to make or report a claim may be punished by a fine or imprisonment, or both. A supervisor who knowingly certifies to any false statement, misrepresentation, or concealment of fact in respect to a claim may also be subject to appropriate felony criminal prosecution.

I. Recommended Changes. Recommended changes to this Instruction will be forwarded through appropriate channels to the Director for Administration and Information Management, ATTN: Chief, Employee Relations Division. Supplementation is not authorized.

J. Effective Date. This Instruction is effective immediately. Addressees should ensure that the contents are made known to appropriate officials and employees under their direction.

FOR THE INSPECTOR GENERAL:

Nicholas T. Lutsch
Assistant Inspector General for
Administration and Information Management

Distribution C

3 Appendices - a/s
- A - Reporting Injuries
- B - Certification of Light/Limited Duty Form
- C - List of Injury Compensation Forms

APPENDIX A
REPORTING INJURIES

A-1. Procedures For Reporting Minor Injuries. (No time lost/no medical treatment.)

STEP	RESPONSIBLE PARTY	ACTION REQUIRED
1	Employee	Reports on-the-job injury to supervisor.
2	Employee	Reports to a Civilian Employee Health Clinic (CEHS) or dispensary (supervisor escorts, if necessary).
3	Supervisor	Identifies witnesses and documents the accident.
4	CEHS/Dispensary	Provides treatement as necessary and employee returns to work.
5	Employee or Supervisor	Obtain a CA-1 Form (Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation). The form is stocked in the Employee Relations Division, Room 125, Arlington, VA.
6	Employee	Completes "Employee Section" of the CA-1. All questions must be answered.
7	Supervisor	Completes "Supervisory Section" of the CA-1 and obtains witness statement(s) (page 1). All questions must be answered.
8	Supervisor	Returns completed CA-1 to the Employee Relations Division, Personnel and Security Directorate, Room 125, within 2 working days.
9	Supervisor	Provides a copy of the injured employee's timecard to the Employee Relations Division for the pay period in which the injury occurred.

If at any time the injury should require medical treatment and/or time off, the supervisor should notify the employee relations division, 693-0257, immediately.

A-2. Procedures For Reporting Injuries Requiring Medical Treatment

STEP	RESPONSIBLE PARTY	ACTION REQUIRED
1	Employee	Reports on-the-job injury to supervisor. (If the employee is incapacitated, anyone at the accident site may notify the supervisor.)
2	Supervisor	Sends or escorts to the CEHS clinic or dispensary. (In extreme cases, an ambulance or rescue squad should be called.) Identifies witnesses and documents the facts of the accident at once.
3	CEHS/Dispensary	Makes initial evaluation and provides treatment. Also advises whether further medical treatment is needed and completes injury record form (CEHS Form).
4	Supervisor or Employee	Obtains forms from Employee Relations Division or alternate office before injured employee seeking additional medical treatment. If employee is too seriously injured to obtain forms before getting medical treatment, supervisor will contact the Employee Relations Division immediately.
5	Employee Relations Division	Provides all necessary forms (see Appendix B) to employee to be given to treating facility for completion. Provides advice and guidance to both the supervisor and employee.
6	Hospital/Physician	Releases the employee as:

Able to Return to Work	**Not Able to Return to Work**
Employee Returns to work site. (If light duty is indicated, employee must return CA-17 (Duty Status Repot) showing any restrictions at the time of return.) Provides Employee Relations Division with original medical reports and provides a copy to the supervisor.	Notifies supervisor of duty status as soon as soon as possible, but no later than the day following the injury.
Supervisor Completes the CA-1 and returns to the Employee Relations Division within 2 days.	Notifies Employee Relations Division of employee's duty status.

Provides copy of timecard to Employee Relations Division for period in which Injury occurred and time lost.	Provides copy of timecards covering date of injury and entire period of disability.

FEDERAL EMPLOYEES NOTICE OF TRAUMATIC INJURY AND CLAIM FOR CONTINUATION OF COMPENSATION

Complete CA-1 Form and return to the Employee Relations Division, Room 125, as soon as possible, but no later than 2 days after the date of the injury.

	Employee Data
Block 1	Self explanatory.
Block 2	Self explanatory.
Block 3	Self explanatory. Note: A common mistake is to put this year's date in place of the actual year of birth.
Block 4	Self explanatory.
Block 5	Self explanatory.
Block 6	Self explanatory.
Block 7	Self explanatory.
Block 8	It is important to indicate dependents because compensation is computed based on this information.
Block 9	A specific location is needed. For example, Ladies Room, 6th Floor, 400 Army Navy Drive, Arlington, VA.
Block 10	Self explanatory.
Block 11	This is the date that the form is completed.
Block 12	Job title as listed on official position description.
Block 13	The employee should be very specific concerning what happened, not just "I fell and hurt my knee, but rather, "When leaving the restroom on the 6th floor, I slipped on a wet spot and fell, twisting my left knee."
Block 14	Specifically identify the part, or parts, of the body injured. For example, left wrist.
Block 15	The employee must choose either "Continuation of Pay" or "Sick and/or Annual Leave" and sign.
Block 16	Witness statements should be obtained by the supervisor (or the employee) following the injury. If there were no witnesses, so state.
	Official Supervisor's Report
Block 17	Leave Blank.
Block 18	Self explanatory.
Block 19	Self explanatory.

Block 20	Self explanatory.
Block 21	Self explanatory.
Block 22	Date supervisor became aware (or was notified) of the injury.
Block 23	If the employee seeks no outside medical treatment, such as a hospital or private physical, but is seen only at the Civilian Employees Health Service clinic or dispensary, this is not considered "stopping work." Enter "Employee did not stop work" in this space. If the employee seeks outside medical treatment on the same day as the injury, but reports to duty the next work day, the time off on the day of the injury is charged to administrative leave on the time card. If the employee seeks outside medical treatment any time after the injury and/or is declared by a physician to be incapacitated for duty, this is considered "stopping work."
Block 24	Leave blank.
Block 25	Leave blank.
Block 26	Date employee returns to duty following the injury.
Block 27	If you question whether the employee was in the performance of duty, please contact the Employee Relations Division, on 693-0257.
Block 28	If you question this, please contact the Employee Relations Division on 693-0257.
Block 29	Self explanatory.
Block 30	Self explanatory.
Block 31	This should not be the Civilian Employees Health Service Clinic or the dispensary unless the employee did not seek outside medical treatment, such as a hospital or private physician.
Block 32	Date the employee was first treated by facility listed in block 31.
Block 33	Obtain medical documentation from employee.
Block 34	If you question this, please contact the Employee Relations Division on 693-0257.
Block 35	Controvert means "dispute" or "challenge." If you dispute the employee's entitlement to COP, contact the Employee Relations Division, on 693-0257, immediately. (See paragraph 7b.)
Block 36	This must be completed in order for Department of Labor to compute compensation.
Block 37	Please put office telephone number in case the Injury Compensation Program Administrator has any questions.

Block 38	Check one block.

Page 3 - <u>Receipt of Notice of Injury</u>

This should be completed by the supervisor and the original copy returned to the employee.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data

1. Name of employee (Last, First, Middle): DOE, JOHN JOSEPH
2. Social Security Number: 123-45-6789
3. Date of birth (Mo. Day Yr.): 7 25 52
4. Sex: ☒ Male ☐ Female
5. Home telephone: (212) 143-4567
6. Grade as of date of injury: Level 7 Step 5
7. Employee's home mailing address (include city, state, and zip code): 143 Birch Street, Anytown, VA 23125
8. Dependents: ☒ Wife, Husband ☒ Children under 18 years ☐ Other

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine): 2nd Floor, Men's Bathroom, 400 Army Navy Drive
10. Date injury occurred (Mo. Day Yr.): 11 15 89
Time: 8 : 30 ☒ a.m. ☐ p.m.
11. Date of this notice (Mo. Day Yr.): 11 15 89
12. Employee's occupation: Auditor
13. Cause of injury (Describe what happened and why): As I was leaving the Mens Room, I slipped in a puddle of water and fell down with my weight on my left knee.

a. Occupation code: LEAVE BLANK
14. Nature of injury (Identify both the injury and the part of body, e.g., fracture of left leg): Bruised left knee cap
b. Type code: BLANK
c. Source code: BLANK
OWCP Use - NOI Code: BLANK

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.

☐ b. Sick and/or Annual Leave

Signature of employee or person acting on his/her behalf: John L. Doe

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled, is subject to felony criminal prosecution and may, under appropriate provisions, be punished by a fine or imprisonment, or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

End of Employee Report

Witness

16. Statement of witness (Describe what you saw, heard, or know about this injury): As I entered the mens room, I saw Mr. Doe on the floor. He said he had just slipped in some water that was on the floor.

Frank Murphy — Name of witness
Frank Murphy — Signature of witness
11/16/89 — Date signed
400 Army Navy Drive, Alexandria, Virginia 22202 — Address, City, State, Zip Code

Figure A-2, Completed Form CA-1

Official Supervisor's Report: Please complete information requested below

Supervisor's Report

17. Agency name and address of reporting office (Include city, state, and zip code) — OWCP Agency Code

Personnel and Security Directorate

OSHA Site Code

Employee Relations Division, Room 434

Zip Code

Arlington, VA 22202

18. Employee's duty station (Street address and zip code) — Zip Code

DoD-IG, Arlington, VA 22202

19. Regular work hours From: 8 :00 ☐ a.m. ☐ p.m. To: 4 :30 ☐ a.m. ☒ p.m.

20. Regular work schedule ☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

21. Date of injury: 11 15 89

22. Date notice received: 11 15 89

23. Date stopped work: 11 15 89 Time : ☒ a.m. ☐ p.m.

24. Date pay stopped: NA

25. Date 45 day period began: NA

26. Date returned to work: 11 16 89 Time 8 :00 ☒ a.m. ☐ p.m.

27. Was employee injured in performance of duty? ☒ Yes ☐ No (If "No," explain)

28. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? ☐ Yes (If "Yes," explain) ☒ No

29. Was injury caused by third party? ☐ Yes ☒ No (If "No," go to item 31.)

30. Name and address of third party (Include city, state, and zip code)

NA

31. Name and address of physician first providing medical care (Include city, state, zip code)

Dr. Hector Doctor

1 Main Street

Anytown, VA 07156

32. First date medical care received: 11 15 89

33. Do medical reports show employee is disabled for work? ☐ Yes ☒ No

34. Does your knowledge of the facts about this injury agree with statements of the employee and/or witness? ☐ Yes ☒ No (If "No," explain)

35. Does the employing agency controvert continuation of pay? ☐ Yes (If "Yes," explain) ☒ No
(See instructions for explanation of "controvert")

36. Pay rate when employee stopped work: $ 24,000 Per year

Signature of Supervisor and Filing Instructions

37. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Corine C. Whats

Name of supervisor (Type or print)

Corine C. Whats — 11/16/89

Signature of supervisor — Date

Director, AUDIT — 555-5555

Supervisor's Title — Office phone

38. Filing instructions
☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
☒ No lost time, medical expense incurred or expected: forward this form to OWCP
☐ Lost time covered by leave, LWOP, or CO: forward this form to OWCP

CA-1
(Rev. 3/86)

Figure A-2 (continued)

Disability Benefits for Employees under the Federal Employees' Compensation Act (FECA)

The FECA, which is administered by the Office of Workers' Compensation Programs (OWCP), provides the following benefits for job-related, traumatic injuries:

(1) Continuation of pay for disability resulting from traumatic, job-related injury, not to exceed 45 calendar days. (To be eligible for continuation of pay, the employee, or someone acting on his/her behalf, must file Form CA-1 within 30 days following the injury; however, to avoid possible interruption of pay, the form should be filed within 2 working days. If the form is not filed within 30 days, compensation may be substituted for continuation of pay.)

(2) Payment of compensation for wage loss after the 45 days, if disability extends beyond such period.

(3) Payment of compensation for permanent impairment of certain organs, members, or functions of the body (such as loss or loss of use of an arm or kidney, loss of vision, etc.), or for serious disfigurement of the head, face, or neck.

(4) Vocational rehabilitation and related services where necessary.

(5) Full medical care from either Federal medical officers and hospitals, or private hospitals or physicians, of the employee's choice. Generally, 25 miles from the place of injury, place of employment, or employee's home is a reasonable distance to travel for medical care; however, other pertinent factors must also be considered in making selection of physicians or medical facilities.

At the time an employee stops work following a traumatic, job-related injury, he or she may request continuation of pay or use sick or annual leave credited to his or her record. Where the employing agency continues the employee's pay, the pay must not be interrupted until:

(1) The employing agency receives medical information from the attending physician to the effect that disability has terminated;

(2) The OWCP advises that pay should be terminated; or

(3) The expiration of 45 calendar days following initial work stoppage.

If disability exceeds, or it is anticipated that it will exceed, 45 days, and the employee wishes to claim compensation, Form CA-7, with supporting medical evidence, must be filed with OWCP. To avoid interruption of income, the form should be filed on the 40th day of the COP period. Form CA-3 shall be submitted to OWCP when the employee returns to work, disability ceases, or the 45 day period expires.

For additional information, review the regulations governing the administration of the FECA (Code of Federal Regulations, Title 20, Chapter 1) or Chapter 810 of the Office of Personnel Management's Federal Personnel Manual.

Privacy Act

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a), you are hereby notified that:

(1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the office receives and maintains personal information on claimants and their immediate families.

(2) The information will be used to determine eligibility for and the amount of benefits payable under the Act.

(3) The information may be used by other agencies or persons in matters relating directly or indirectly to the matter of the claim, so long as such agencies or persons have received the consent of the individual claimant, or complied with the provisions of 20 CFR 10.

(4) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits (disclosure of a social security number is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled).

Receipt of Notice of Injury

This acknowledges receipt of Notice of Injury sustained by
(Name of injured employee)

John Joseph Doe

Which occurred on (Mo., Day, Yr.)

11/15/89

At (Location)

400 Army Navy Drive, Arlington, VA 22202

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
Corine C. Whato		

CA-1

Figure A-2 (continued)

Instructions for Completing Form CA-1

Complete all items on your section of the form. If additional space is required to explain or clarify any point, attach a supplemental statement to the form. Some of the items on the form which may require further clarification are explained below.

Employee (Or person acting on the employee's behalf)

13) Cause of injury

Describe in detail how and why the injury occurred. Give appropriate details (e.g.: if you fell, how far did you fall and in what position did you land?)

14) Nature of injury

Give a complete description of the condition(s) resulting from your injury. Specify the right or left side if applicable (e.g., fractured left leg; cut on right index finger).

15) Election of COP/Leave

If you are disabled for work as a result of this injury and file CA-1 within thirty days of the injury, you are entitled to receive continuation of pay (COP) from your employing agency. COP is paid for up to 45 calendar days of disability, and is not charged against sick or annual leave. You may elect sick or annual leave if you wish, but compensation from OWCP may not be claimed during the 45 days of COP entitlement. (You may not claim compensation to repurchase leave used during this period.) Also, if you later change your election, the agency is not obliged to convert past periods of leave to COP.

Your agency may controvert (dispute) your entitlement to COP, but must continue pay unless the controversion is based on one of the nine reasons listed in the instructions for item 35.

If you receive COP, but OWCP later determines that you are not entitled to COP, you may either change COP to sick or annual leave or pay the employing agency back for the COP received.

Supervisor

At the time the form is received, complete the receipt of notice of injury and give it to the employee. In addition to completing items 17 through 38, the supervisor is responsible for obtaining the witness statement in item 16 and for filling in the proper codes in shaded boxes a, b, and c on the front of the form. If medical expense or lost time is incurred or expected, the completed form should be sent to OWCP within two working days after it is received.

The supervisor should also submit any other information or evidence pertinent to the merits of this claim.

If the employing agency controverts COP, the employee should be notified and the reason for controversion explained to him or her.

17) Agency name and address of reporting office

The name and address of the office to which correspondence from OWCP should be sent (if applicable, the address of the personnel or compensation office).

18) Duty station street address and zip code

The address and zip code of the establishment where the employee actually works.

29) Was injury caused by third party?

A third party is an individual or organization (other than the injured employee or the Federal government) who is liable for the injury. For instance, the driver of a vehicle causing an accident in which an employee is injured, the owner of a building where unsafe conditions cause an employee to fall, and a manufacturer whose defective product causes an employee's injury, could all be considered third parties to the injury.

31) Name and address of physician first providing medical care

The name and address of the physician who first provided medical care for this injury. If initial care was given by a nurse or other health professional (not a physician) in the employing agency's health unit or clinic, indicate this on a seperate sheet of paper.

32) First date medical care received

The date of the first visit to the physician listed in item 31.

35) Does the employing agency controvert continuation of pay?

COP may be controverted (disputed) for any reason; however, the employing agency may refuse to pay COP only if the controversion is based upon one of the nine reasons given below:

a) The disability results from an occupational disease or illness;

b) The employee is a volunteer working without pay or for nominal pay, or a member of the office staff of a former President;

c) The employee is neither a citizen nor a resident of the United States or Canada;

d) The injury occurred off the employing agency's premises and the employee was not involved in official "off premise" duties;

e) The injury was proximately caused by the employee's willful misconduct, intent to bring about injury or death to self or another person, or intoxication;

f) The injury was not reported on Form CA-1 within 30 days following the injury;

g) Work stoppage first occurred six months or more following the injury;

h) The employee initially reported the injury after his or her employment was terminated; or

i) The employee is enrolled in the Civil Air Patrol, Peace Corps, Youth Conservation Corps, Work Study Programs, or other similar groups.

Employing Agency - Required Codes

Box a (Occupation Code), Box b (Type Code), Box c (Source Code), OSHA Site Code

The Occupational Safety and Health Administration (OSHA) requires all employing agencies to complete these items when reporting an injury. The proper codes may be found in OSHA Booklet 2014, Recordkeeping and Reporting Guidelines.

OWCP Agency Code

This is a four-digit (or four digit plus two letter) code used by OWCP to identify the employing agency. The proper code may be obtained from your personnel or compensation office, or by contacting OWCP.

CA-1
(Rev. 3/86)

Figure A-2 (continued)

APPENDIX B
CERTIFICATION OF LIGHT/LIMITED DUTY

INSTRUCTION: Complete and forward to:

Office of the Inspector General
Department of Defense
Personnel and Security Directorate
Employee Relations Division
Room 125
Arlington, VA 22202

A. Print/Type:

1. Employee's Name: _____
(Last, First, MI)

2. Employing Office:
(i.e., Component Division/Branch)

_____
(Title)

_____
(Component Division/Branch)

3. Supervisor's Name: _____
(Last, First, MI)

4. Supervisor's Phone Number: _____

B. Check one of the following statements:

____ 1. The above referenced employee has been given light/limited duty assignments in accordance with the attending physician's direction and certification on the CA-17.

____ 2. The above referenced employee has not been given light/limited duty assignments. No positions are available within the organization.

_____
Supervisor's Signature Date

APPENDIX C
INJURY COMPENSATION FORMS

OWCP Form CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
OWCP Form CA-2	Federal Employee's Notice of Occupational Disease and Claim for Compensation
OWCP Form CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
OWCP Form CA-3	Report of Termination of Disability and/or Payment
OWCP Form CA-6	Official Superior's Report of Employee's Death
OWCP Form CA-7	Claim for Compensation on Account of Traumatic Injury
OWCP Form CA-8	Claim for Continuing Compensation on Account of Disability
OWCP Form CA-16	Authorization for Examination and/or Treatment
OWCP Form CA-17	Duty Status Report
OWCP Form CA-20	Attending Physician's Report
OWCP Form CA-20a	Attending Physician's Supplemental Report (attach to CA-20)
Form HCFA-1500	Health Insurance Claim Form

Injury compensation forms listed above may be obtained from the Employee Relations Division, Personnel and Security Directorate.